# LEARNINGS FROM THE FIRST COVID-19 RECOVERY SITES

## FINDINGS FROM THE COMMUNITY ENGAGEMENT PROCESS

HEALTH COMMONS SOLUTIONS LAB & DR. GILLIAN KOLLA

# Objective

To learn from the experience of clients, staff and community partners about **how best to shelter and care** for those who are COVID+ and experiencing homelessness

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# COMMUNITY ENGAGMENT PROCESS

A rapid community engagement process around the opening of future COVID-19 recovery sites for people experiencing homelessness.

**Consultation Objectives:**

- Facilitate multi-directional conversations between community partners and leadership/staff working at the current sites about how to best support clients
- Create forums to activate the expertise and resources of community partners to support clients living at the sites before, during and after their stay
- Leverage learnings from current site implementations to support the planning of future sites
- Engage directly with clients staying at the current sites to understand their experience and identify opportunity areas
- Engage directly with staff working at the current sites to understand their experience and identify opportunity areas

# WHO WE TALKED TO

We spoke to executive leadership, site managers, clinicians, and non-clinical front-line service providers including community service workers and peer workers. This included those directly involved in the current/future site operations, as well as those providing services in the community.

**Description of touchpoints:**

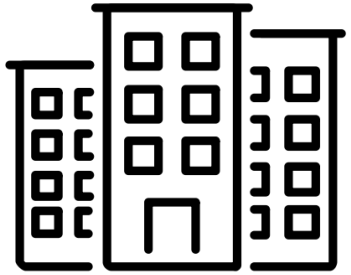
- 20 community leaders in a 90-minute consultation session regarding the second site for recovery
- 45+ community partners, leadership, staff working at the current sites for a 2-hour discussion regarding key operational questions (n=40)
- 50 person consultation with the *Weekly COVID-19 Front Line Harm Reduction Call* - followed by survey
- Interviews and conversations with 21 community partners, leadership, shelter directors, hospital assessment team leads, staff working at current sites
- Four site visits with 9 staff
- Interviews with 9 clients currently staying at the sites
- Presentations to the Toronto Regional Homelessness and Shelter Working Group

While Indigenous leaders have participated in these sessions, an Indigenous-led process has been convened to create a culturally relevant pathway for Indigenous people as part of the COVID-19 response

# ELEMENTS OF THE REPORT

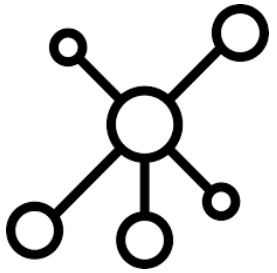
## LEARNINGS FROM THE CLIENTS

Gathering insights from the client perspective to capture and share what matters most to them.



## LEARNINGS FOR THE SITES

Synthesis of what we heard including practical ideas about what might help future sites.



## LEARNINGS FOR THE HEALTH SYSTEM

While not the intention of this process, several system gaps emerged from the feedback.

# COVID Response requires us to reimagine the service model

Creating a new model of care where clinical and social care teams are working side by side

The pandemic has required an unprecedented response from the public health, shelters and healthcare partners to help meet the needs of people experiencing homelessness. There is no roadmap – it has required that partners continuously test, refocus and shift.

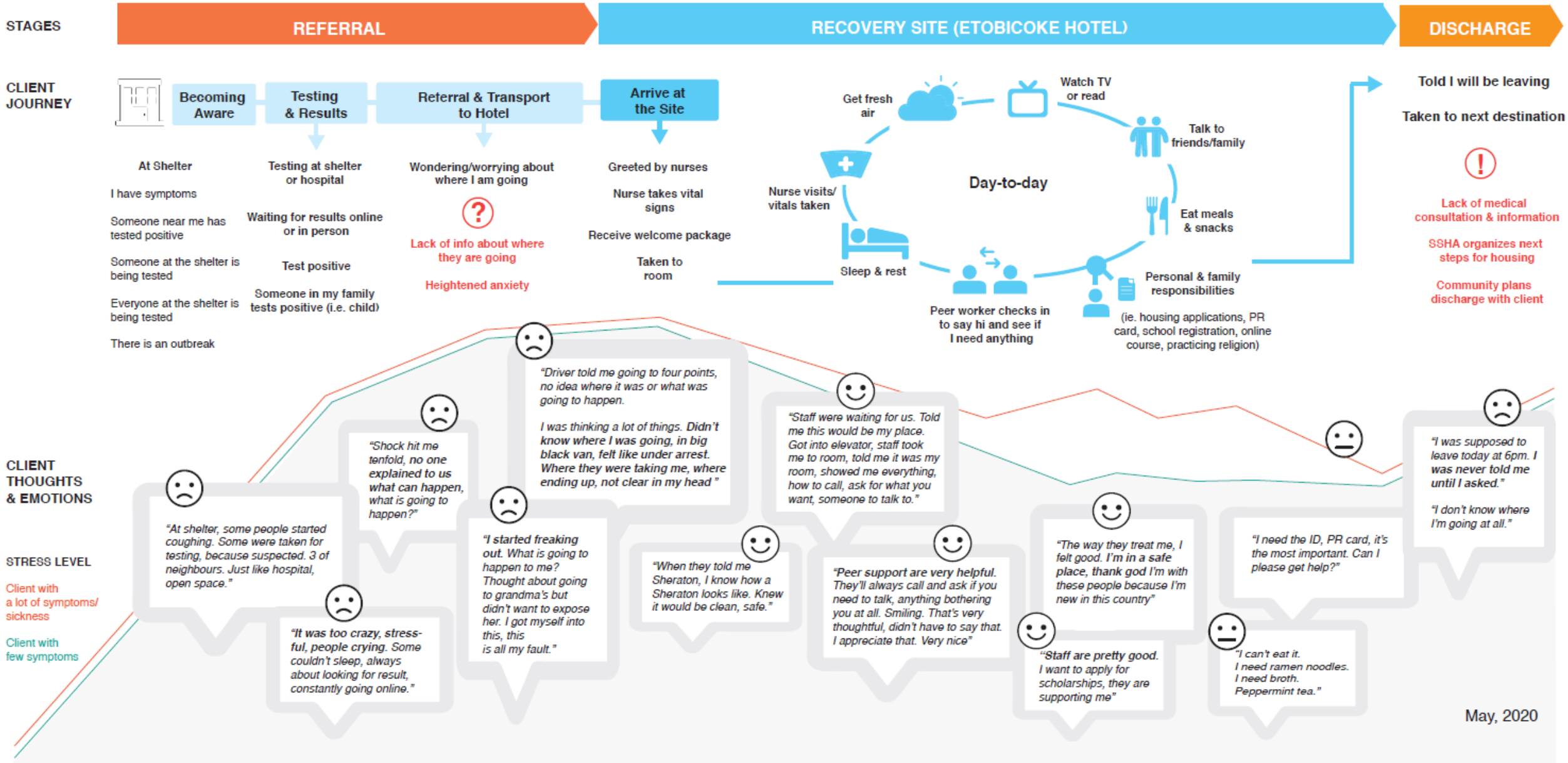
**For the City, shelters, hospital assessment teams – how can we improve access to the available spaces?**

- Biggest areas of anxiety and confusion were at referral and discharge – there are no previously established pathways between systems
- Process for testing is poorly understood and may be leading to delays
- Eligibility is now less restrictive, but lack of communication means perception persists
- Need bolder action to support transfers – from shelters and from hospital
- Need more coordinated planning and continuity of care at discharge

**At the COVID Recovery Site – people's experience is positive, but we need to continue to adapt and evolve the model**

- City, community, peers and clinical are working side by side
- Initial focus on medical model no longer fits – majority of work onsite is social care
- Risk framework, leadership roles and decision making must catch up
- Team onsite is iterating and problem solving based on the flexibility and goodwill of staff - strong culture of 'yes' has been a major factor in success
- Rebalancing of power and resources must catch up to the multi disciplinary nature of care that is more shelter than hospital

# ANCHORING IN THE CLIENT EXPERIENCE



# KEY TAKE AWAYS FROM ENGAGEMENT

## TESTING AND REFERRAL

- Overall experience feels chaotic and stressful
- Delays and restrictive eligibility are putting shelter clients and staff at risk
- Lack of information at every step of the process is creating anxiety for clients
- Shelters are wasting valuable time navigating a complex, often restrictive referral process
- Perception that physicians are extremely conservative about who is allowed into the recovery site

## MULTI DISCIPLINARY SITE MODEL

- Overall experience at the site is positive for clients
- Initial 'medical model' doesn't match the current profile of clients (mostly asymptomatic or sub-acute)
- Risk aversion among physicians, coupled with the fact that they are often not onsite, is consistently raised
- Onsite community and peer workers have most contact with clients and consistently identified as providing exceptional support

## DISCHARGE AND TRANSFER OUT

- More information needed early in a client's stay; more transparent planning (including around housing options from SSHA) in the 48 hours prior to discharge
- Need for a medical touchpoint with clients being discharged to allow them to ask remaining health or COVID-related questions
- Continuity of care on discharge – including explicit linkage to community care providers for ongoing medication, OAT, MAP, safer supply and psychosocial needs

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# TESTING AND REFERRAL

Complex process that is poorly understood across the people we talked to (clients, shelter directors, hospital assessment team leads, community partners, site staff)

Referral pathway remains unclear and difficult to navigate

Clients remain in the dark about where they are going and what services are onsite for them when they arrive.

## WHAT WE HEARD FROM CLIENTS

**TESTING**

**Little information was provided about what a COVID+ result would mean**

*"It was too crazy, stressful, people crying. Some couldn't sleep, always looking for results, constantly going online."*

*"No, I had no information"*

**RECEIVING RESULTS**

**Poor communication about what happens next led to unnecessary fear and anxiety**

*"I was wondering why aren't they giving me my results? They told me they were taking me to another place. They didn't explain the results to me, it was just written on paper."*

**REFERRAL TO SITE**

**No one they talked to knew about where they were going**

*"They never told me where I was going…I said am I going back to where I was? They said "No. You are going to another place"*

*"I didn't know where I was going, in big black van, it felt like I was under arrest. Where are they taking me? "*

*"Even a pamphlet would have put my mind at ease"*

**ARRIVAL**

**Most people were pleasantly surprised when they arrived**

*"I was little bit scared of where I'm going. Then I came here and saw place and said, it's okay."*

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# TESTING AND REFERRAL

Trouble getting access to the COVID positive site by shelter staff has been an ongoing theme in the feedback from shelters

- Delays in testing when a shelter has identified a possible case
- Restrictive eligibility to recovery sites means that COVID + clients have nowhere to go

# WHAT WE HEARD FROM SHELTER STAFF AND HOSPITAL ASSESSMENT TEAMS

TESTING

**Multiple players, decentralized decision-making is creating confusion**

*"Our big concern is that once we do all that testing where do people go? We want to make sure there is a plan in place when all these people start testing positive."*

*"We are having to develop a process from scratch."*

RECEIVING RESULTS

**It's not clear how to trigger the intake following a COVID+ test**

*"I am sending in a team to do testing, but Public Health is telling me they don't know what happens if people test positive. Does that sound correct to you? "*

REFERRAL TO SITE

**Eligibility is centered on medical criteria and many clients are deemed too complex**

*"I call it the Goldilocks test. I can't figure out how to get people into the site, they are either too complex or not sick enough. "*

*"Right now it all just seems like a black box of uncertainty"*

ARRIVAL

**Opinions were split on a centralized pathway, but all saw a need for better coordination**

*"We understand there are some priority sites, but we want to make sure that all shelters getting access to testing."*

# Take Aways

## TESTING AND REFERRAL

**Simple communication tools:** Everyone believes that some simple communication tools for clients would go a long way to improve the experience – the destination is actually good news.

**Risk of delaying COVID+ clients in shelters outweighs the risk of transferring them:** Community partners felt that eligibility may be overly centered on medical criteria and suggested there may be an opportunity to keep more people out of hospital by taking a transparent, case by case approach to referrals.

**Information gaps and misinformation:** The need for large scale onsite testing in the community has put new demands on the referral process. The various players and their respective roles are not well understood among providers.

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# MULTI DISCIPLINARY CARE MODEL

Clients and sites have benefited from staff coming from different areas of expertise, knowledge and perspectives – clinical and social.

Majority of the team onsite is nursing, community support & harm reduction workers, and peer workers. The overall experience reported by clients has been positive, without any tensions identified by staff being visible to clients

## WHAT WE HEARD FROM CLIENTS

**1** **Clients are having a good experience at the site**

*"Truthfully, I never expected anything from them. My real concern was my health. They went beyond my expectations"*

*"It's like you're home. You get your own room, your TV… it's very comfortable."*

*"To all the unsung heroes, thank you . I know how vulnerable I was."*

**2** **All staff are going above and beyond AND peer workers were a particular highlight for clients**

*"If it wasn't for the peer support, I don't think I would have lasted this long "*

*Clients were inspired by peer workers and curious about the opportunity to give back by volunteering and working*

**3** **The conditions at the site make it easy to stay in place to recover**

*"This is a better place to be, and someone wouldn't want to leave. If I get a place like this, I'll be fine."*

# MULTI DISCIPLINARY CARE MODEL

Sites are not quite hospitals and not quite shelters – this serves clients well but presents new challenges.

Multidisciplinary model is a work in progress - staff roles, policies and processes have adapted and iterated.

As the picture of care needs emerges across the client population, it may be necessary to reconsider the number and type of different roles to better reflect the requirements

# WHAT WE HEARD FROM STAFF AT THE SITE

## 1 Most clients are sub acute and do not require a medical model

Having many types of providers, including harm reduction and peer workers creates many avenues for clients to get their needs met.

Peer workers are considered by everyone to be integral to the model offering necessary flexibility in the tasks they take on.

Nurses are the clinical backbone of the site – while physicians have increased their onsite presence from the initial virtual only model, there remains a persistent view that they are not onsite frequently enough.

## 2 A "culture of yes" allows staff to proactively engage with clients about their needs and supports staff to meet those needs

*"The reason that we don't have explosive behaviours is because of the frequency of the touchpoints and the quality of the social interactions. Everyone is solving for yes"*

## 3 Challenges of operationalizing a mixed medical and social care model often fall to individuals to absorb the pressures created

Dynamics of physician oversight repeatedly raised as a challenge – majority of client issues have been related social care where the community team have more expertise.

Operational decision-making should be led by those onsite and closest to clients except in cases where there is an escalation of medical issues.

Take Aways

# MULTI DISCIPLINARY CARE MODEL

**Care needs are largely non-medical:** Creating multiple avenues for clients to express their needs and having high quality social interactions has been key to keeping people in place.

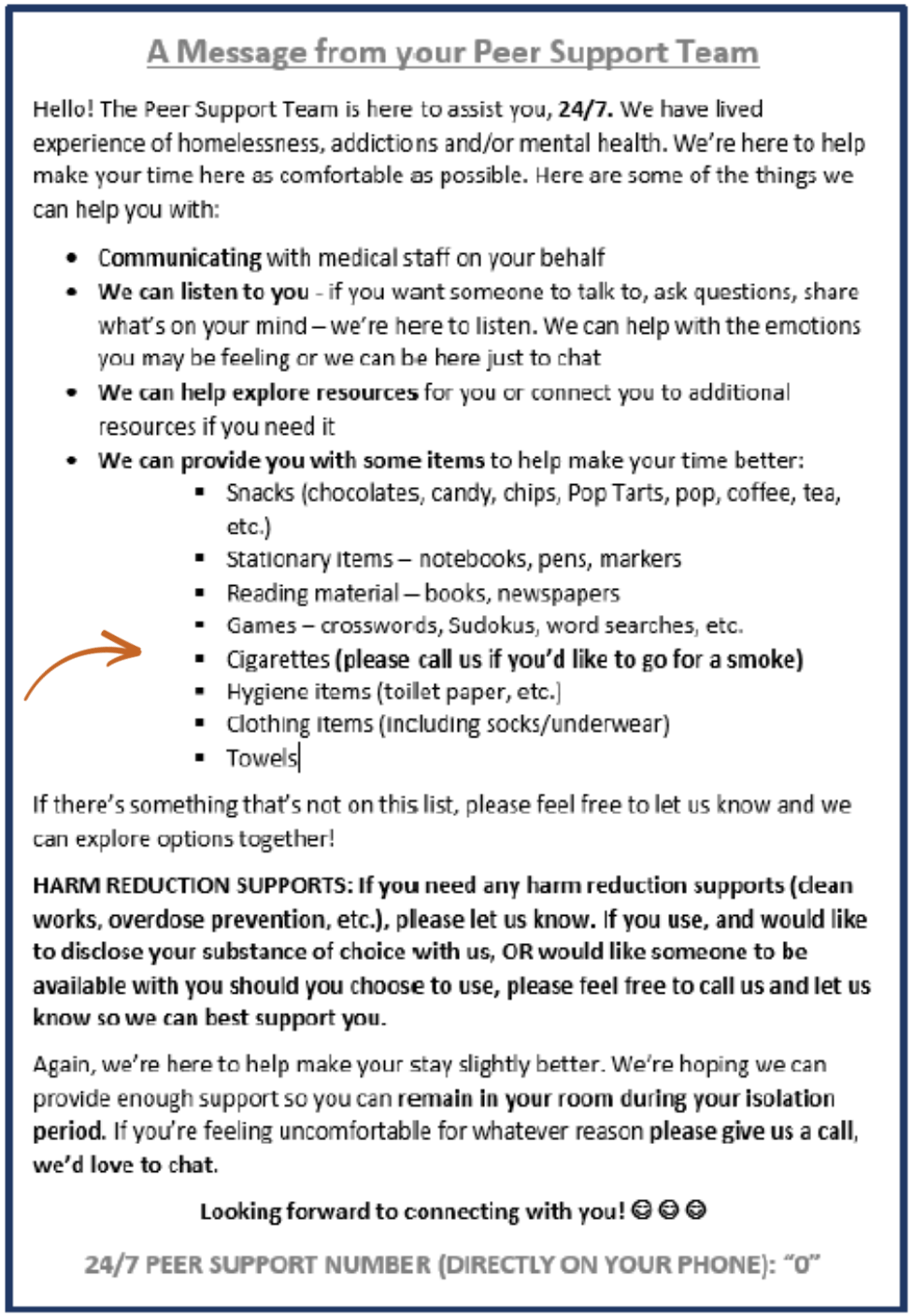
**Rebalance the power and resourcing to reflect the community role:** while care at the site has evolved in response to clients needs, dynamics inherent in traditional medical model remain. Staffing ratios of peer workers is outpaced by the high demand their service. The value and onsite presence of community & harm reduction workers is not reflected in their role in decision making.

**Clarity of roles and delineation of executive and operational decision-making:** lack of clarity regarding multiple leadership tables has led to perception of a top down approach. Operational decision-making should defer to those onsite and recognize community expertise on non-clinical issues.

Physician roles and expectations should be clarified – e.g. regular planned (onsite) touchpoints with clients, escalation of COVID-related or medical issues vs day-to-day decision-making.

# WHAT DO PEERS DO?

*Heavy smokers will need cigarette breaks 2-3/hr*



## A Message from your Peer Support Team

Hello! The Peer Support Team is here to assist you, **24/7.** We have lived experience of homelessness, addictions and/or mental health. We're here to help make your time here as comfortable as possible. Here are some of the things we can help you with:

- **Communicating** with medical staff on your behalf
- **We can listen to you** - if you want someone to talk to, ask questions, share what's on your mind – we're here to listen. We can help with the emotions you may be feeling or we can be here just to chat
- **We can help explore resources** for you or connect you to additional resources if you need it
- **We can provide you with some items** to help make your time better:
  - Snacks (chocolates, candy, chips, Pop Tarts, pop, coffee, tea, etc.)
  - Stationary items – notebooks, pens, markers
  - Reading material – books, newspapers
  - Games – crosswords, Sudokus, word searches, etc.
  - Cigarettes **(please call us if you'd like to go for a smoke)**
  - Hygiene items (toilet paper, etc.)
  - Clothing items (including socks/underwear)
  - Towels

If there's something that's not on this list, please feel free to let us know and we can explore options together!

**HARM REDUCTION SUPPORTS: If you need any harm reduction supports (clean works, overdose prevention, etc.), please let us know. If you use, and would like to disclose your substance of choice with us, OR would like someone to be available with you should you choose to use, please feel free to call us and let us know so we can best support you.**

Again, we're here to help make your stay slightly better. We're hoping we can provide enough support so you can **remain in your room during your isolation period.** If you're feeling uncomfortable for whatever reason **please give us a call, we'd love to chat.**

**Looking forward to connecting with you!** 😊 😊 😊

**24/7 PEER SUPPORT NUMBER (DIRECTLY ON YOUR PHONE): "0"**

*102 wellness checks a day.*
*Chatting or having conversations (mostly via telephone) with clients*

*Actively listening to clients (mostly via telephone) as they express their emotions regarding their experience in isolation*

*Helping navigate resources, i.e. clients may want to find/share social service resources, relay information to members within their support network, learn about amenities available on-site to help create a comfortable isolation period,*

*Advocate on behalf of clients to other partners, including nurses, community members or City staff*

*Providing harm reduction supports, including distribution of sterile supplies, wellness checks, relaying information to nurses, overdose prevention, etc.*

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# DISCHARGE AND TRANSFER OUT

For people without secure housing, the process should not be treated as a discharge, but as a housing transition.

Housing and destination is the thing that clients care about most, often mentioning it more frequently than health-related issues.

## WHAT WE HEARD FROM CLIENTS

### Lack of information fuels anxieties and misinformation

*"I was supposed to leave today at 6/6:30. Never told me until asked. They're supposed to tell me so I can prepare things. They said they would come to me when leaving."*

*"Some girls that were here that went to Scarborough. Sounds like everyone is going there when they leave here."*

*"I'm going to a hotel in Brampton. No, I don't know anything else."*

*"I don't know what's happening to me. Monday will be 2 weeks."*

### What's next means something different to every person

*"My daughter has kidney disease, the doctor said it's easy to pick up infections. So I need housing. One person here, I forgot her name, she's doing a good job. Trying to get me housing, talking to my social worker"*

*"This is my concern. To work or study, I still don't know. After I deliver I will check on studying, working.*

### Need for a medical touchpoint at end of stay

*"The thing that puzzles me is don't we get re-tested after this thing? At the end, how do you know where we go, we won't be exposed again?"*

*"Can we catch virus again? No one knows?"*

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# DISCHARGE AND TRANSFER OUT

Planning for the transition out of the hotel should start early in a client's stay, with heightened and transparent discharge planning (including around housing options from SSHA) in the 48 hours prior to discharge.

With client permission, the community team on site can coordinate with community care providers to coordinate supports.

There is a strong need to ensure continuity of care on discharge.

## WHAT WE HEARD FROM COMMUNITY PARTNERS AND SHELTER STAFF

**1** **Discharge planning should start on 'Day 1' and continue throughout the stay. Intensive discharge planning with client fully participating should occur in final 48 hours.**

*"Discharge planning should start on day 1. "Where would you like to go and what will you be doing once you're better?" "How will being here affect your safety, your finances, your relationships, etc."*

**2** **Community team provides linkage between community and onsite care**

*"Individualized care plan and case management - regular check-ins with a warm hand off"*

*"People without clear linkages to community supports (case management, counselling, hep c care, etc.) should be offered options"*

**3** **Discharge planning must ensure continuity of care, particularly for clients who require ongoing medication, OAT, MAP, safer supply and psychosocial supports.**

*"People who are started on safer supply while in isolation should be maintained on those prescriptions on release."*

Take Aways

# DISCHARGE AND TRANSFER OUT

While recovery sites can't influence the availability of housing, much can be done to support people on their transition out. Longer discharge periods, with medical teams providing a 'heads-up' that discharge will occur in 48 hours may be helpful, along with transparent planning and communication from SSHA with clients about housing options.

**Medical touchpoint at discharge:** Clients often had COVID-related health questions at the end of their stay, and a medical touchpoint at discharge would allow them a chance to have questions addressed

**Planning should be more visible to clients:** Multiple teams are involved and finding housing options can be labour intensive. Involving clients in their transfer plans and letting them know what to expect can have a big impact on their anxiety levels as they prepare to leave the site.

**Continuity of care:** Priority should be given to coordinating supports currently in place – e.g. mental health, case management – as well as supports initiated at the site – e.g. safe supply, managed alcohol programs, applications underway for education or housing, etc.

# OPPORTUNITIES – *recap for the recovery sites*

## TESTING AND REFERRAL

- Simple communication tools to improve the client experience and support community partners
- Avoid delaying COVID+ clients in shelters by simplifying access and taking a case by case approach to eligibility
- Proactively address information gaps and misinformation to make it easier for shelters to undertake large scale testing

## MULTI DISCIPLINARY SITE MODEL

- Create multiple avenues for clients to express their needs – most are non-medical
- Rebalance the power and resourcing to reflect the central role of community and peer staff expertise
- Clarify roles and delineation of executive and operational decision-making
- Clarify physician roles and expectations

## DISCHARGE AND TRANSFER OUT

- Medical touchpoint at discharge to allow clients a chance to have questions addressed
- Planning that is more visible to clients and helps them know what to expect
- Continuity of care to ensure supports currently in place are coordinated as part of the transfer

# SSHA and Toronto Region Central Functions

It is anticipated that congregate living spaces such as shelters will continue to be places of higher transmission of the virus. Many of the issues identified in the community engagement highlight the need for more centralized coordination of partners and a system level response to appropriately address them.

## TESTING & REFERRAL

### PRIORITY LIST FOR ONSITE TESTING

Plan for testing underhoused or in congregant living

Prioritize list and deploy assessment teams from hospitals

Deploy team to shelter

Develop a plan for symptomatic people who are sleeping rough

### TESTING AND REFERRAL

Triaging of Clients who are COVID +

Develop criteria for when to transfer out of a shelter rather than remain in place (e.g. Willowdale)

Communicate with shelter staff and clients what the plan for transfer

*Shelter staff would be better able to support clients in preparing for testing if they if they information about the process ('what happens next?'), referral pathways, and the recovery sites.*

## CARE MODEL

### STANDARD CARE MODEL DURING RECOVERY

***Common basket of supports:***

Onsite medical/ clinical supports

Multi disciplinary supports for remaining in place: harm reduction and psychosocial supports

Peer support

***Common policies***

### SHELTERING COVID + CLIENTS IN PLACE

Support for shelter teams to scale up staff response for increased cleaning, cohorting COVID + clients

Support sites with health protection and PPE support

IPAC support from hospitals

## DISCHARGE

### EARLY COMMUNICATION OF NEXT LOCATION

Communication of discharge location should be made 48 hours in advance to allow of continuity of care planning

***Some stable and permanent form of housing is the number one priority for clients***